

QUALITY STANDARDS FOR DERMATOLOGY

PROVIDING THE RIGHT CARE FOR PEOPLE WITH SKIN CONDITIONS



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Contents

Acknowledgements			
Foreword by Baroness Masham	01	STANDARD 5 Models of care and links to other services	28
Executive summary	02	STANDARD 6 Diagnostic investigations	33
Introduction	05	STANDARD 7 Clinical governance	37
STANDARD 1 Principles of dermatology care	07	STANDARD 8 Information governance	41
STANDARD 2 Patient and public involvement	13	APPENDICES	
STANDARD 3 Appropriately trained staff	17	APPENDIX A Membership of the project groups	47
STANDARD 4 Clinical assessment and management	22	APPENDIX B Levels of care for skin conditions in the UK	48
		APPENDIX C The commissioning cycle	50
		APPENDIX D Dermatology education and training	51
		APPENDIX E Links to other services	56
		APPENDIX F Clinical guidance, audit and risk management	58
		APPENDIX G Key performance indicators	59
		Glossary of abbreviations	61



Foreword by Baroness Masham of Ilton

I am delighted to write the foreword for this very important guidance. Having been the President of the Psoriasis Association for over 20 years and as a long-term member of the All Party Parliamentary Group on Skin, I wholeheartedly support these standards and will take a very keen interest in the way they are received and implemented.

Skin disease in the UK is:

- the most prevalent disease in under 16s (1 in 5 babies have eczema)
- the second most common disease in adults

Each year 24% of the population present to their GP with a skin problem.

Skin cancer is the most common form of cancer in the UK and malignant melanoma incidence rates in Britain have more than quadrupled since the 1970s.

Millions of people in the UK are affected by skin conditions and the best possible care is vital so that they remain as healthy as they can and are able to lead fulfilling lives.

To deliver care of this order, commissioners, clinicians and patients must know what constitutes an acceptable level of service and be enabled to develop services that meet the needs of everyone with a skin condition. Because these standards are based on research-backed evidence, they can be used to highlight services that offer real value for money and, crucially, to challenge inadequate service provision and request improvements.

Skin diseases not only cause great discomfort and disfigurement, they also affect people psychologically and socially, each in different ways. I am delighted that these standards not only cover the essential services needed to treat the skin disease itself, but also highlight the vitally important holistic services that ensure the whole person is treated as effectively as possible.

It is vital to remember that each skin disease can have a wide range of symptoms and effects beyond the purely clinical. For example:

- the mother exhausted from constantly wet-wrapping her persistently crying baby who has eczema
- the 15-year-old boy who hanged himself with his school tie because he was being bullied about his acne
- the woman with vitiligo who no longer leaves the house because she has been subjected to ridicule
- the woman who no longer has sex because of her lichen sclerosus

These are just a few of the millions of people whose lives are affected by skin conditions and could be improved by implementing these standards across the healthcare economy, so that services really do meet the needs of the individual.

I offer my congratulations to all involved in developing these excellent and very useful standards and add my fervent hope that they will be widely applied.

A handwritten signature in cursive script that reads "Masham of Ilton."

Baroness Masham of Ilton

Executive summary

The standards are intended for use in any service that provides care for people with skin conditions. They bring together best practice and existing guidance, and aim to meet the needs of commissioners of services in a changing NHS.

Anyone commissioning services is well aware of the need to commission for quality, innovation, productivity and prevention and to use resources in the most cost-efficient manner. As the way that services are commissioned continues to evolve, the twin challenges of assessing the quality of care offered by various service providers and ensuring that patients can access care of a high standard remain. These standards are intended as a reference guide to what constitutes a good-quality service for both commissioners and providers of care for patients with skin conditions.

There are eight standards and each comprises a series of recommendations, with rationales and references to support these, a list of implications for commissioners and at least one key performance indicator. This executive summary highlights only the key points from each standard.

Standard 1: Principles of dermatology care

This covers the overarching principles that should underpin the provision of care for people with skin conditions. These principles are absolutely crucial to the delivery of good-quality care and should be viewed as non-negotiable.

- Every local health economy must provide for full and fair patient access to the full range of high-quality dermatology services at all levels of care - to this end, models of care should be developed using stakeholder commissioning groups.
- Consistent, nationwide high-quality care that meets independent quality standards, such as those developed by NICE, is a cornerstone of the NHS for the 21st century –it can only be achieved if there is clear local support for independent quality standards.
- People with skin conditions should have their care managed at a level appropriate to the severity and complexity of their condition, acknowledging that this may vary over time.
- All services should have access to a range of supportive services that can help meet the holistic needs of people with skin conditions - these could include psychological support, access to medical social workers, camouflage services and occupational therapy.

Because it is so fundamental to the delivery of good-quality care, we urge all readers to read Standard 1 in full on pages 7-12.

Standard 2: Patient and public involvement

- The best way to design and develop user-centred dermatology services that meet the needs of people with skin conditions is to involve potential and current service users in their design, development and ongoing governance.
- Commissioners should develop and support a stakeholder commissioning group that includes patient representation, as outlined in the Primary Care Contracting document *Providing Care for Patients with Skin Conditions: Guidance and Resources for Commissioners*.

- Each dermatology service, whether integrated or stand alone, should have a patient panel that is involved in its development and governance.

Standard 3: Appropriately trained staff

- Individual competences will depend on job role and should be relevant to services being commissioned, ie they should match patient need.
- Healthcare professionals are responsible for maintaining their competence, but this must be supported by commissioners and providers working together within the context of a local governance framework that is commissioned and regularly monitored.
- Specialist dermatology services should play a key role in supporting the delivery of education and training across a range of providers.
- Standardisation of educational provision (across professional disciplines and educational providers) is important, and lack of standardisation represents a risk.

Standard 4: Clinical assessment and management

- Patients should be seen by the right person in the right place with suitable facilities; those with special or particular needs, such as children, should be seen by appropriate staff in facilities that meet their specific needs.
- Patients should be fully informed about their diagnosis and management and be involved in decisions about their care.
- Patients should have access as needed to all treatments approved by national agencies, eg NICE, and treatment should be carried out in a safe, competent and timely manner according to national and local standards.
- Those with long-term conditions should be offered appropriate ongoing care and access and re-access to services as needed.

Standard 5: Models of care and links to other services

- Models of care for people with skin conditions should be developed by stakeholder commissioning groups using consensus guidance to ensure they reflect the needs of the health community.
- All services for people with skin conditions should be integrated to ensure patients can move between levels of care as necessary (this requires established links between generalist, specialist and supra-specialist services to facilitate advice, support and onward referral, irrespective of provider).
- All health communities should establish clinical care pathways with other clinical services – these should be clear, agreed and used by all service providers to ensure equity of access for all patients. (For patients with skin cancer the specific national guidance on care pathways should be followed).
- Triage and referral management, where used, should be performed by experienced, suitably trained clinicians with the sole aim of ensuring that patients are seen in a timely fashion by appropriately trained healthcare professionals.

Standard 6: Diagnostic investigations

- Dermatological investigations should be requested, carried out and reported by appropriately trained staff in accordance with local and national guidelines.
- Specimens should be transported in a safe manner.
- Results should be available and reported to the patient in an appropriate time frame.

Standard 7: Clinical governance

- It is essential that clinical governance arrangements are embedded in clinical practice to enable services to constantly review and measure themselves in terms of effectiveness, safety and patient experience.
- Commissioners should ensure that requirements for clinical governance are explicit in all contracts with providers of dermatology services and should monitor services against the agreed standards.
- Specialist services must be able to show the results of regular audit against national and local guidance - this will support compliance with Care Quality Commission requirements.
- Strong clinical leadership is required for clinical governance to work well, and specialist services should provide this within local health communities.

Standard 8: Information governance

- Data (including digital images) should be obtained, recorded, held, altered, retrieved, transferred, destroyed or disclosed in accordance with the Common Law Duty of Confidentiality, Caldicott Guidance, the Data Protection Act 1998 and other national and professional guidelines.

The key performance indicators from all standards are brought together at the back of the document in Appendix G.

Introduction

The 2010 NHS White Paper *Equity and Excellence: Liberating the NHS* highlighted the importance of quality standards and measurable clinical outcomes in ensuring optimal patient care. Recent NHS reform has led to an increasing number of providers delivering services, and this number may increase further. In this complex landscape it is vital that commissioners of services have clear, accessible information about what constitutes high-quality care. This information should reflect the views of patients, the public and healthcare professionals and be based on the best available evidence.

The British Association of Dermatologists (BAD) has led a project to develop standards of care, describing the key elements of best practice that people with skin conditions are entitled to expect. A working group was set up with representation from patient organisations, the BAD, BDNG, BSPD, PCDS, RCGP, commissioners, GPs, GPwSI, nurses and pharmacists, and with input from the Department of Health. These standards are the output of that group, although the final content reflects comments from a wider audience by consultation.

The standards are based on best available evidence and are applicable to any services commissioned by the NHS, including those in the independent or third sectors. They are intended as a precursor to, as well as to help inform, future NICE quality standards. While the standards are intended to be particularly useful in commissioning services in England, it is hoped they will be adopted as good practice throughout the UK.

Each year 24% of the population present to their GP with a skin problem. The aim of the standards is to support equitable access to high-quality care for people with skin conditions, and to form a basis for the development of any NICE quality standards. If services are delivered to these standards, there is every expectation that outcomes for people with skin conditions will improve.

This document covers the more generic aspects of care, with the expectation that standards for specialist services such as skin cancer surgery or phototherapy will follow.

Commissioners and a range of organisations were actively involved in the development of the standards, which have been endorsed by the British Association of Dermatologists (BAD), the British Dermatological Nursing Group (BDNG), the National Eczema Society (NES), the Psoriasis Association, the Primary Care Dermatology Society (PCDS), the Royal College of General Practitioners (RCGP) and the Skin Care Campaign (SCC).

THE STANDARDS



STANDARD 1

Principles of dermatology care

The principles specified in this standard should underpin the provision of care for people of all ages with skin conditions.

1.1 Recommendations

Note that the rationale (which may include background details and further information) appears in italic type after each recommendation.

1.1.1 High-quality care

The three key components in defining quality of care are:

- effectiveness
- safety
- patient experience

Services should constantly review and measure themselves against these three key components, following the specific guidance for the specialty.¹

Commissioners and providers of services must ensure that people with skin conditions have access to a full range of dermatological services and, where appropriate, that these are in concordance with NICE guidance or national standards.

Rationale

Care that meets independent quality standards, such as those developed by NICE, has been identified as a cornerstone of the NHS for the 21st century.² Local support for independent quality standards is vital to ensure the delivery of consistent, nationwide high-quality care.

Clinical governance, including clinical leadership - a key factor in high-quality care - is covered in Standard 7.

1.1.2 Levels of care

People with skin conditions should have their care managed at a level appropriate to the severity and complexity of their condition, acknowledging that this may vary over time. The principles of care are therefore described in relation to the level of care required:

- self-care (Level 1)
- generalist care (Level 2)
- specialist care (Level 3)
- supra-specialist care (Level 4)

People with skin conditions who manage their conditions themselves (Level 1 care) should be supported with high-quality patient information and input from suitably trained nurses, patient support groups and community pharmacists.³

People with skin conditions needing generalist (Level 2) care are managed initially through self-referral to their GP. Level 2 care should also include access to input from suitably trained nurses.

Any patient whose skin condition cannot be managed by a generalist will need to be referred for specialist care (Level 3) and/or supra-specialist services (Level 4).

Rationale

Rationale Levels of care are described in more detail at Appendix B.

Models of care, links between the different levels of care and links to other services are covered in detail in Standard 5.

The skills and knowledge of the healthcare professionals should always match the level of care provided, whatever the location.³

1.1.3 Information and support for people with skin conditions

People with skin conditions at all levels of care should be given up-to-date patient information leaflets that ideally meet the Information Standard⁴ and/or be directed to relevant patient support groups. As information prescriptions develop, patients should be made aware of the information they will provide.

Information and support should also be offered to family and carers as appropriate.

Rationale

'Information' is broadly defined to include health promotion and self-monitoring advice. Wherever appropriate, healthcare professionals should offer health promotion advice and explain to people with skin conditions the benefits of self-monitoring for skin changes. Patients should be made aware of all information resources, including patient information leaflets, web-based resources and information prescriptions.

1.1.4 Holistic care

All services should have access to a range of supportive services that can help meet the holistic needs of people with skin conditions. These could include among others: psychological support, access to medical social workers, camouflage services and occupational therapy.

Rationale

There is good evidence that skin conditions are associated with increased psycho-social morbidity.³ Holistic care is therefore important to ensure that all the needs of patients are met.

1.1.5 Patient Choice

When referring people to more specialist services, GPs should inform them about the types of providers of dermatology care available (including location and type of premises) to help them choose the most suitable service.⁵

Service providers must supply full and accurate information, regularly updated.

Rationale

People with skin conditions can only make fully informed choices if service providers supply accurate, up-to-date information on services provided, waiting times and so on, and if these are explained clearly by their GP.⁵

1.1.6 Equity of access to dermatology services

Every local health economy must provide for full and fair access to the full range of high-quality dermatology services at all levels of care. To this end, models of care should be developed using stakeholder commissioning groups.

Referral guidelines in relation to excluded treatments for so-called 'low-priority conditions' (such as benign skin lesions) should be explicit, widely publicised and clearly explained to patients by healthcare professionals.

Rationale

A local healthcare needs assessment is vital to determine the amount and type of skin disease in a community³ and the services needed to ensure fair access for all. Where decisions are taken not to provide services, responsibility for this should be shared by the stakeholders. Priority setting is one of the steps that commissioners are expected to consider as part of the commissioning cycle.⁶ See Appendix C.

Other factors affecting access also need to be taken into account, such as the need for interpreting services, local public transport and timing of service provision.

1.1.7 Access to specialist and supra-specialist services – waiting times

Clear referral pathways to specialist and supra-specialist (Levels 3 and 4) services should be in place, operating within the appropriate timescales, complying with national targets and meeting NICE guidance.

Rationale

Every patient should receive the first definitive treatment for their condition within 18 weeks of the date of initial referral, as required by law in the NHS constitution.⁷

People with skin conditions referred urgently should be able to access services considerably faster.

People with suspected melanoma, squamous cell carcinoma or rare skin cancers should be seen within two weeks by specialists who are part of a skin cancer multidisciplinary team (MDT) (Level 3 or 4).^{5, 8}

1.1.8 Access to specialist services - location and premises

Care should be convenient for people with skin conditions and provided at a location within a suitable distance of their home.⁹ Some people may still need to travel considerable distances for more specialised services (mainly supra-specialist, Level 4).

Premises for all services should conform to the Department of Health's *Standards for Better Health*.¹⁰

Rationale

Many people with skin conditions (such as those undergoing phototherapy) need to attend dermatology treatment services two or three times a week for several weeks, which makes public and/or patient transport services particularly important.

The location of services and the types of premises used to deliver dermatology services should be informed by findings from a healthcare needs assessment and by service user feedback of their experience.⁶

1.1.9 Services for children and young people

Services for children should be child centred and provided in a child-friendly environment with appropriately trained staff.¹¹ Integrated care pathways should be established and due consideration should be given to planning transitional care for young people progressing to adult services.

Rationale

Children and young people have specific needs. To ensure these are met, all healthcare professionals who work with children and young people with skin conditions should be appropriately trained and consideration should be given to the correct clinical environment and facilities. Services should take account of the principles outlined in the National Service Framework for Children, Young People and Maternity Services: Core Standards.¹¹

1.1.10 Expertise on skin disease in ethnic groups

All services should have knowledge of the ways some skin diseases can affect ethnic groups differently. If the relevant expertise is not available to treat specific patients locally, it is important that there is access to services that can do so.

Rationale

Over 6.5% of the UK population belong to a minority ethnic group. Skin diseases manifest in and affect the skin of various ethnic groups differently and expertise is needed to assess and meet differing needs.

1.1.11 Treatment and consent

People with skin conditions should be treated with dignity and their privacy respected. The services of a chaperone should be made available where appropriate. Patients should be given relevant information that reflects any religious, ethnic or cultural needs and takes into account whether they have any physical or learning disability, sight or hearing problem, or language difficulty.

Healthcare professionals should explain the range of treatments available for the condition, including the possible benefits and risks.

All treatments offered should be in accordance with current NICE guidance, where appropriate.¹²

Treatment and care should be given only with the patient's informed consent before the procedure takes place.¹³ Healthcare professionals should be fully aware of Department of Health and General Medical Council guidance in relation to The Mental Capacity Act and obtaining consent from minors.^{14, 15, 16}

Rationale

People with skin conditions have the right to be involved in discussions and make informed decisions about their treatment and care. All steps should be taken to ensure that the patient fully understands the treatment choices available and that their informed consent is given before any procedure takes place. This includes making provision as appropriate for children, non-English speakers and anyone who may have difficulty in understanding the choices available (for example, people whose care and support is covered by the terms of the Mental Capacity Act).^{14, 15}

1.1.12 Aftercare and follow-up

People with skin conditions seen in Level 3 and Level 4 (specialist and supra-specialist) services need to be given clear information about their ongoing care, including any review arrangements, the results of investigations and what to do if they have difficulties between appointments.

Patients should always be asked if they wish to receive a copy of their clinic letter. Their response should be recorded and acted upon. Clinic letters containing information on management should be set out clearly.

Clinic letters should be received by the GP in a timely fashion and the results of any further investigations should be reported promptly.

Rationale

Good practice guidelines published by the Department of Health in 2003¹⁷ cover the right of patients to receive a copy of clinician's letters.

1.1.13 Research

Clinical research and development should be fostered and encouraged in all health communities. Providers of care should be aware of current trials (such as those co-ordinated by the UK Dermatology Clinical Trials Unit) and be encouraged to recruit to studies as appropriate.

Rationale

Recent government white papers¹⁸ make it clear that NHS patients should be given the opportunity to participate in high-quality clinical research, echoing a directive set out earlier in the NICE skin cancer guidance of 2006.⁸ Clinical research has been highlighted as crucial to NHS improvement, which has led to development of a national research strategy for the NHS, 'Best Research for Health'. Further research is vital for developing a sound evidence base to understand the causes, prognosis and treatment of skin conditions. All clinical departments, including general practice, should participate where possible.

The UK Dermatology Clinical Trials Unit (www.ukdctn.org), part of the Centre for Evidence Based Dermatology, is an independent charitable organisation affiliated to the BAD, that identifies possible clinical trials and develops them into larger studies across the UK.

All research funded by the National Institute for Health Research (NIHR) and its associated charities, such as the British Skin Foundation, is eligible for entry onto the national research portfolio.

The Comprehensive Clinical Research Network (www.crncc.nihr.ac.uk) has its own Dermatology Speciality Group that is tasked to deliver dermatological studies on the national portfolio.¹⁹

1.2 Implications for commissioning

1.2.1

Commissioners should facilitate the development of models of care for people with skin conditions using a stakeholder commissioning group. The commissioning cycle (see Appendix C) should be used to underpin this process, with a health care needs assessment for the local health community as the first step.^{3, 6}

1.2.2

Commissioners should commission services that support the local healthcare needs assessment and can meet national targets in relation to access times.

1.2.3

Commissioners will need to ensure that whatever model of care is developed, where it exists all current NICE guidance is followed – and continues to be followed as it is revised and new guidance is published.

1.2.4

All dermatological services that are commissioned to provide care for people with skin conditions should include within the service specification an explicit statement in relation to requirements for education and training, assessment of competence, ongoing maintenance of skills, and clinical governance arrangements.

1.2.5

Commissioners should involve stakeholders in any decisions about excluded treatments for 'low-priority conditions' and such decisions should be widely publicised.

1.2.6

Where commissioners are considering value for money, quality (as measured by effectiveness, safety and patient evidence) should be measured against the standards in this document using available tools, including patient-recorded experience and outcome measures (PREMs and PROMs).

1.3 Key performance indicators

1.3.1

Standard 1 underpins the other standards and covers the principles of care. The key performance indicators for the management of skin conditions are listed under individual standards 2—8.

1.4 References

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STANDARD 2

Patient and public involvement

It is the responsibility of all commissioners and clinical stakeholders to ensure that patient and public involvement is an integral part of all service developments and governance and has sufficient status, direction and leadership to be as effective as possible – this standard discusses how best to achieve this.

2.1 Recommendations

Note that the rationale (which may include background details and further information) appears in italic type after each recommendation.

2.1.1 Patient involvement

The best way to design and develop user-centred dermatology services that meet the needs of people with skin conditions is to involve potential and current service users in their design, development and ongoing governance. It is vital to seek the views of patients regarding the services they currently receive and those that would improve their treatment experience. These views should be used to inform the delivery, development and continuing governance of all services.

It is the responsibility of commissioners to develop strategies to involve a diverse range of people with skin conditions across the local skin health community. This process begins with education and support for all concerned (including clinicians and commissioners) in how to best involve people with skin conditions effectively.

Each dermatology service, whether integrated or stand alone, should have a patient panel that is involved in its ongoing development and governance.

Each service should develop strategies that include:

- setting up and supporting a patient panel
- developing methods to involve all patients, including children and young people
- guaranteeing anonymity if needed

Rationale

Commissioners and clinicians should embrace the opportunity of drawing upon the knowledge, experience and expertise that people with skin conditions can bring to the full commissioning cycle (see 1.2.1).

2.1.2 Public involvement

The public, including non-users of dermatology services, should always be involved when any significant redesign or development is planned,^{1,2} as should organisations belonging to the wider health community, including patient support groups and charities, local involvement networks (LINKs) and patient panels.^{3,4}

It is essential that public involvement is fully effective and that services meet the needs of neighbourhoods, as outlined in the *Equity and Excellence: Liberating the NHS White Paper*.⁵

Rationale

As outlined in the NHS constitution,² it is part of a good NHS service to ensure that any new developments, including expansion and decommissioning, go to public consultation to ensure the broadest possible range of opinions and support.

2.1.3 Patient-reported experience and outcome measures

Each provider should collect and report patient-reported experience measures (PREMs) and outcome measures (PROMs).⁶ The data captured should include holistic outcomes and experience of the whole clinical pathway. Measures should include:

- overall experiences
- access
- communication
- interaction with professionals
- co-ordination
- care and respect
- privacy and dignity
- health information
- involvement in health decisions
- signposting to relevant voluntary organisations and support groups

The development of standard frameworks involving people with skin conditions across the skin health community would support effective and consistent data collection. The information collected should be used to inform service development.

Rationale

Patient-reported experience measures (PREMs) are measures of how a patient experiences their care pathway. PREMs usually include such measures as:

- *speed of referral*
- *respect shown to them*
- *clarity of the care plan*
- *their involvement in decision making*
- *suitability of the environment in which they are seen*
- *effectiveness of interdisciplinary communication*

Patient-reported outcome measures (PROMs) are measures of a patient's health. They typically take the form of short, self-completed questionnaires that measure the patient's health status at a single point in time. They are usually administered before and after health interventions and are used to assess the effectiveness of the treatment, care and support provided. There is a range of dermatology-specific quality-of-life tools that can be used to measure clinical outcomes, such as the Dermatology Quality of Life Index (DLQI) developed at Cardiff University.⁷

Many people with skin conditions may have long-term ongoing treatment and support and will require adapted PROMs and PREMs throughout their pathway.

From April 2009 the new Standard NHS Contract for Acute Services requires providers to report on PROMs for certain elective healthcare interventions. It is hoped that a multi-stakeholder group, similar to the one that has produced these standards, will develop PREMs and PROMs for use across the whole skin health economy.

Used properly, PREMs and PROMs will provide information that has previously been obtained, with varying degrees of success, through service user questionnaires.

2.1.4 Priority setting

Effective consultation and input from the local stakeholder commissioning group (see 1.2.1), will enable commissioners to develop clear arrangements for priority setting and to provide evidence both of the need for any low-priority frameworks or treatment exclusions and of the process by which these decisions were reached.

Rationale

Input from all stakeholders means that decisions can be fully informed and the responsibility for these decisions is shared among all the stakeholders.

2.2 Implications for commissioning

2.2.1

Commissioners should develop and support a stakeholder commissioning group that includes patient representation, as outlined in the Primary Care Contracting document *Providing Care for Patients with Skin Conditions: Guidance and Resources for Commissioners*.⁸

2.2.2

Commissioners should expect providers to contribute to a patient and public involvement strategy for the local skin health economy. The strategy should include clear feedback mechanisms.

2.2.3

Commissioners and providers should properly consult with the local population, both users and non-users of services, and must take the outcomes of the consultation into account in the development of their local vision for skin health, and in the monitoring and evaluation of services managing skin conditions.

2.2.4

Commissioners should work with the local health economy to develop local quality measurement frameworks for providers of dermatology services and should be involved in the development of PREMs and PROMs, which will provide a consistent approach to measuring and improving the quality of all services.

2.2.5

Service provision must include all aspects of the service, including prescribing and access to treatments. The stakeholder commissioning group should agree any changes in prescribing formularies and develop clear guidelines for the easiest access to all NICE-recommended treatments.

2.3 Key performance indicators

2.3.1

Evidence from providers of services managing skin conditions that they have developed and implemented a patient and public involvement plan, which includes use of PREMs and PROMs, an effective patient panel, evidence of patient feedback and the provider's response to this.

2.3.2

Evidence of public and patient involvement when changes to services are proposed.

2.4 References

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2. NHS (2010) *The NHS Constitution*. London: NHS. (Available at www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx)
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5. Department of Health (2010) *Equity and Excellence: Liberating the NHS*. Department of Health White Paper. London: The Stationery Office. Gateway reference 14385. Cm 7881. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)
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7. See <http://www.dermatology.org.uk/quality/dlqi/quality-dlqi.html>.
8. NHS Primary Care Contracting (2008) *Providing Care for Patients with Skin Conditions: Guidance and Resources for Commissioners* (www.pcc.nhs.uk/uploads/dermatologyguidance.pdf)

2.5 Further supporting documents and guidance

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STANDARD 3

Appropriately trained staff

This standard explores the opportunities and challenges involved in ensuring that people with skin conditions are seen by healthcare professionals with the appropriate skills and competence to meet their care needs. The standard does not comment on every professional group that may provide care for people with skin conditions, but the recommendations are intended to be applicable to all, wherever care is delivered.

3.1 Recommendations

Note that the rationale (which may include background information and further detail) appears in italic type after each recommendation.

3.1.1 Competence to deliver services

People with skin conditions should be cared for by appropriately skilled healthcare professionals who have demonstrated their competence to fulfil the required role. This includes the particular requirements, skills and training needed for those working with children and young people.

Because of the high prevalence of skin conditions in the community, it is particularly important that all healthcare professionals providing generalist care (Level 2) achieve an appropriate level of competence in managing skin conditions.

Individual practitioners are responsible for maintaining their own competence but must be supported in this by their employers and commissioners.

Rationale

A range of healthcare professionals with varying levels of knowledge and mix of skills delivers services relating to the management of skin conditions.

Appropriate competences will depend on job role and to an extent professional discipline. Competences should be relevant to the service that is being commissioned (patient need) and individuals should work within the scope of their own competence. The standards required to achieve a particular competence should be the same, regardless of professional group (eg skin surgery skills).

Different professional groups may have different guidance around certain competences and the steps required to ensure safe practice, eg in relation to prescribing.

3.1.2 Clinical leadership

The clinical leadership required to support education, training and ongoing clinical governance arrangements for all providers of dermatological care should be both explicit and commissioned.

Clinical leadership should always be strongly supported by dermatology specialists working in partnership with other providers of care for people with skin conditions.

Rationale

Providers of specialist dermatology services should have a key role in supporting the delivery of education and training across the range of providers. Their expertise should be harnessed and commissioned to support local service development and provide leadership in all education and training issues.

Specialists are particularly useful in educating GPs and other primary care professionals (Level 2) to help them improve the diagnosis, management and/or referral of people with skin conditions.

While clinical leaders are usually consultant dermatologists, this need not always be the case.

3.1.3 Training and assessment

Training in the skills and competence required to care for people with skin conditions should be standardised in content. Multi-professional education and training should be encouraged where appropriate, ie where learning outcomes and level of competence are equivalent.

Standards for training for consultant dermatologists (specialists and supra-specialists working at Levels 3 and 4) and GPwSIs (Levels 2 and 3) are well established. For other professional groups, notably nurses, pharmacists and GPs providing primary (first-point-of-contact) care, training is variable. Significant effort is required to address this and ensure improved levels of competence.

Agreed mechanisms should be in place for assessing clinical competence. These should be standardised across all professional groups.

Those assessing competence should be trained to do so.

Rationale

Currently professional disciplines are trained in relation to skin condition diagnosis and management in different ways. Standardisation of content, quality and quantity of education provision (across professional disciplines and education providers) is important and the lack of standardisation is a risk.

Particular challenges and issues unique to different professional disciplines are outlined below. (For an at-a-glance guide to current dermatology education and training see Appendix D.)

3.1.3.1 GPs

Undergraduate medical training in dermatology has historically been poor and inadequately formalised.¹ In some cases it is less than five days.

Some attempt has been made to improve postgraduate training with the introduction of the new curriculum, which includes skin problems, for GPs in training.² However, the breadth of training required by a GP means it is difficult to assess all areas of curriculum in detail, so there is limited assessment of competence related to diagnosis and management of skin conditions.

3.1.3.2 GPs with a Special Interest (GPwSI)

A GPwSI has skills and knowledge over and above that of the average GP, takes referrals from other GPs and works unsupervised, usually in a community setting.

Detailed guidance for the accreditation and training of GPwSI in dermatology and skin surgery was published in 2007 and updated in 2011.³

This guidance should form the basis for training for GPwSI and could also be used for developing competences for other professionals working at this level.

GPwSI can also help educate and support colleagues in primary care to improve the diagnosis, management and/or referral of people with skin conditions.

3.1.3.3 Consultants and trainees holding a National Training Number (NTN) in dermatology

Consultant dermatologists are required to meet specific training requirements to appear on the General Medical Council Specialist Register of Dermatologists in the UK. The training covers the diagnosis, investigation and management for the whole range of skin diseases. All dermatologists are trained in skin surgery.⁴

Formal annual appraisals for consultants are likely to be required as part of relicensing and revalidation. Appropriate competences, including those for sub-specialty training are yet to be developed.

3.1.3.4 Staff grade, Associate Specialist and Speciality (SAS) doctors⁵

SAS doctors, formerly known as Non Consultant Career Grade doctors (NCCGs), include doctors with a wide range of experience, who work within consultant-led specialist dermatology teams. Most do not apply for a Certificate of Eligibility for Specialist Registration (CESR), equivalent to a Certificate of Completion of Training (CCT). New entrants to the grade will all be specialty doctors and must have a minimum of four years' postgraduate experience and at least two years' experience in dermatology. There is also a group of experienced dermatology Associate Specialists who typically work unsupervised; however, recruitment to this grade is now closed.

There is no generic set of competences by which this group of doctors is trained or assessed. All are subject to annual appraisal.

3.1.3.5 Nurses

A number of universities provide post-qualifying education for nurses in various aspects of skin disease management. As these are not standardised, nurses work to no recognised set of competences. Nor is there a recognised educational standard/level of competence for the holder of a specialist nursing post.

The Royal College of Nursing and British Dermatological Nursing Group have written a competence framework for dermatology nursing,⁶ but this needs urgently revisiting if it is to provide a national competence framework.

Nurses providing specialist and supra-specialist services need specialist post-qualifying education, which may be highly focused on a particular area of care, eg light therapy. Non-specialist nurses working in primary care (Level 2) require specific dermatology input as part of their ongoing professional development. Nurses in more specialised roles may require more specialised training to reach appropriate competence.

3.1.3.6 Healthcare support workers/assistants

Increasingly healthcare support workers or assistants and pharmacy healthcare assistants are being trained to support healthcare professionals and patients in dermatological services. National Vocational Qualifications (NVQs) are widely used to determine competence of more generic skills but do not relate specifically to those skills needed in dermatology services.

3.1.3.7 Pharmacists

Pharmacists play an increasingly important role in the primary care team and are often consulted before GPs.

Training for community pharmacists covers general healthcare, but specific competences, such as skin conditions, are not individually assessed unless undertaken as a voluntary module in their undergraduate training.

3.1.3.8 Pharmacists with a Special Interest (PhwSI)

A PhwSI is an expert in a certain type of condition and is commissioned to play a specific role in the primary care team.⁷

In order to become accredited a PhwSI has to undergo extra competence-based training and demonstrate knowledge and skills beyond the usual professional competence required for a pharmacist.

There is specific guidance for training PhwSI in skin conditions,⁸ following the general guidance published in 2007.⁹

3.1.4 Maintaining competence

Service providers should be able to produce evidence that the professionals delivering care for the management of skin conditions are competent to do so – not just at recruitment but continuously throughout their employment.

Service providers should make adequate provision to support staff in maintaining competence in the management of people with skin conditions, eg through continuing professional development (CPD). This should be reflected in an individual's knowledge skills framework (KSF).

All practitioners should work within a robust clinical governance framework that is able to demonstrate conformity with maintenance of national and local standards (see Standard 7 for more detail).

Rationale

All healthcare professionals have an obligation to maintain their own clinical competence. However, there is often a lack of clarity about how providers are required, by commissioners, to demonstrate the ongoing competence of the staff who work for them.

Commissioners and providers of services therefore need to work together to ensure that maintenance of competence forms part of a robust local governance framework that is commissioned and regularly performance monitored.

3.2 Implications for commissioning

3.2.1

Clinical leadership, provided by dermatology specialists to support the delivery of education, training and governance across the range of providers and levels of care in a health community, should be fostered, supported and explicitly commissioned as part of a local service specification.

3.2.2

All service providers should demonstrate a workforce development and continuity strategy.

3.2.3

Providers of generalist care (Level 2) are likely to have education and training needs in relation to skin disease management. Appropriate education, training and governance structures should be commissioned to meet national standards and reflect local needs. Outcomes of training should meet the local needs and gaps in the workforce development plan and continuity strategy.

3.3 Key performance indicator

3.3.1

Competence to deliver services: percentage of staff delivering dermatological services who have successfully completed competence-based training, according to their job role and scope of practice, and fulfilled relevant update requirements. (Standard 100%)

3.4 References

1. All Party Parliamentary Group on Skin (2004) *Dermatological Training for Health Care Professionals*. London: All Party Parliamentary Group on Skin.
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5. SAS doctors currently include associate specialists, who have at least 10 years postgraduate experience (at least two in dermatology) and staff grade doctors who must have at least three years postgraduate experience. All new entrants to the grade, however, are specialty doctors – their training requirements are set out in the table at Appendix D.
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STANDARD 4

Clinical assessment and management

This standard covers patients' interactions with healthcare professionals and their outcomes. It explains key requirements for both the initial assessment and ongoing care.

4.1 Recommendations

Note that the rationale (which may include background information and further detail) appears in italic type after each recommendation.

4.1.1 The principle of consent

Any interaction between a patient and a healthcare professional is subject to informed consent being given by the patient. Where a patient is not able to give informed consent, the clinician should follow the principles set out in the Mental Capacity Act.¹ For children, they may need to assess whether the child is Gillick competent.²

Rationale

Rational consent is a legal requirement. It can be either explicit (specific consent to carry out a specific action) or implied (inferred from the patient's actions, from the particular situation or sometimes from their silence or inaction).³

4.1.2 History taking

The patient's history should be taken by an appropriate healthcare professional who is properly trained to do so.

The service should provide facilities for the history to be taken in a suitable room where safety and privacy are assured. There should also be a suitable waiting area.

If children are assessed the facilities should be appropriate.

There should be provision for access to translating, interpreting or signing services for those with special communication needs.^{4, 5}

Where the patient may have difficulty in understanding or answering the questions because of a learning disability or mental incapacity, the healthcare professional should follow guidance set out in the Mental Capacity Act 2005¹ and related publications.

Rationale

Dermatological symptoms may be part of a general medical or psychological disorder so accurate and reliable history taking is important, as is a full holistic assessment of each patient's needs.

To avoid failing to identify child protection or other issues of risk or vulnerability, all commissioners and providers need to ensure that local and national guidance on safeguarding children and the Mental Capacity Act are followed, and that all staff are appropriately trained. This applies equally to history taking and examination.

4.1.3 Examination

The examination should be conducted by an appropriately trained healthcare professional.

Privacy should be maintained during dressing, undressing and examination, and the patient should be treated with dignity and respect, taking into account their age and any cultural differences. A chaperone should be available for examination and a chaperone policy should be in place.^{6,7} Where necessary, a nurse with experience in child health should be available.

Those seeing children should follow national and local guidelines for safeguarding children.⁸

Rationale

The presence of a chaperone is intended as a safeguard for patient and practitioner and as a witness to continuing consent of the procedure.^{6,9} The different needs of children should be recognised.¹⁰

4.1.4 Medical photography

Medical photography facilities should be available. Where photographs are taken, this should be done only with the patient's informed consent and in accordance with the General Medical Council's guidelines.¹¹

Rationale

Medical photography is an important component of a dermatological service as it is the best record of the clinical appearance. It facilitates monitoring of treatment and communication with other healthcare professionals.

4.1.5 Investigations

A range of laboratory investigations should be available to support the diagnosis and management of skin diseases. As a minimum, the following should be available:

- point-of-care tests (eg pregnancy tests, mycology)
- biochemical, haematological, microbiological and histopathological tests

The appropriate storage and transport facilities should be in place, as should protocols to ensure specimens are sent within an appropriate time.

The clinician should have direct access for advice to consultants providing all forms of pathology services. Histopathology departments should have links to enable specialist dermatopathology opinions to be obtained when necessary.¹²

Where indicated, more specialised tests may be needed, eg patch testing, photo testing. It is important that services have access to these specialised tests performed by appropriately trained staff and meeting any relevant national standards.

Clinicians should be responsible for ensuring results of investigations are viewed and acted on in a timely manner, including appropriate communication with patients and general practitioners.

Rationale

The list of recommended investigations is the minimum required to support clinical care. In order for them to be effective, it is important that these tests are requested, performed and the results interpreted:

- *in a timely manner*
- *by healthcare professionals with the appropriate training and competence*

Diagnostic tests and laboratory standards are covered in detail in Standard 6.

4.1.6 Diagnosis and management

Patients should be fully informed and subsequently updated on their skin condition.

The following principles should be followed for all forms of management.

- Patients should be fully involved in and informed about decisions concerning the management of their skin condition. Healthcare professionals should always clearly explain to the patient the possible effects of any intervention, both beneficial and adverse. The patient should know who to contact to discuss further management of their condition.
- Patients should have access to all forms of effective treatment irrespective of where they live. The prescribing of high-cost drugs should be in line with national guidance and not determined by local commissioning decisions. If a treatment is not available, this should be explained to the patient and they should be told where it is available, so they can make an informed choice.
- Management decisions should be made taking into consideration evidence-based practice, local and national guidelines and protocols, including NICE guidelines, within a clinical governance framework (for more detail see Standard 7).
- Prescribing of all treatments should be by appropriately trained staff in accordance with local or national prescribing policies. Patients should be informed as to whether their treatment will be prescribed by the primary care or specialist team or by a shared care protocol.
- Treatment should be carried out within a reasonable time and in accordance with local and national standards.
- All treatments should be delivered by competent individuals in a suitable and safe environment, respecting the patient's privacy and dignity. 'Treatment' includes topical treatments and dressings, which are an important part of care for many people with skin conditions.
- In order to maximise safety, adequately maintained equipment (including resuscitation equipment where appropriate) and suitably trained personnel must always be available.
- All healthcare professionals managing people with skin cancer should comply with NICE guidelines.^{13, 14}
- Inpatients should be treated by staff skilled in the treatment of patients with skin conditions.

Rationale

Patients have a right to be given full information about their condition.

All management should be evidence-based, patient-centred, with equitable access to treatment based on clinical need.

Patients have the right to expect that clinical decisions about management will be based on the available scientific evidence. To ensure this is the case, local health communities should follow NICE guidance and any local guidance should be developed with reference to the evidence base.

4.1.7 Review and ongoing care

Patients should be given clear information about how to manage their skin condition, plans for review and, for those with a chronic inflammatory skin condition, advice on how to access care if they need further advice quickly because their condition deteriorates or they are concerned about it.

Certain patients should remain under specialist review where appropriate.

This should include patients:

- with a chronic moderate or severe inflammatory skin condition
- who are immunosuppressed
- with unstable dermatoses requiring modification of treatment
- who have significant solar damage that requires ongoing treatment
- who are undergoing skin cancer management and follow-up (their ongoing care should meet national guidance)^{13, 14, 15}

If these patients are discharged from specialist care, they should ideally have their skin condition assessed annually by a member of the primary care team. Ideally too this should be linked to a medicines review and include, where appropriate, a risk assessment for associated conditions (eg cardiovascular disease for people with psoriasis) and a psychosocial assessment.¹⁶

Patient-reported outcome measures (PROMS) and quality-of-life tools may be useful in standard clinical practice to help assess response to treatment.¹⁷

There should be arrangements in place for integrated shared care with other services, especially for those patients with chronic conditions. Since patients with skin conditions often require input from other specialities apart from dermatology, so dermatology services should have links with the full range of other specialities.

Pathways should be in place for onward referral of conditions that the service cannot appropriately manage, as explained in more detail in Standard 5.

Rationale

Patients with chronic skin conditions should be able to access and re-access care as needed and it is important that Level 2 services have links with specialist dermatological services to provide care not available locally. Management of patients may need to be in collaboration with other healthcare professionals across different levels of care or between different specialties. (See Standard 5 for more on links with other services.) Shared care guidelines, such as, for example, those developed for the use of immunosuppressive drugs,¹⁸ are extremely useful in these situations.

Chronic skin conditions can cause significant physical, social and psychological impairment¹⁹ and an annual review of patients is warranted, including psychosocial assessment and medication review.²⁰

Response to treatment is complex and holistic. PROMS and quality-of-life tools are useful in documenting response to treatment.¹⁷

4.1.8 Patient support services

Patients should have access to:

- suitable nursing expertise for treatment, counselling and education and advice
- high-quality information from reliable sources about their condition and about relevant support groups and charities

Rationale

Patient support groups provide a great deal of help and advice and can have an extremely positive effect on the patient's experience of treatment and quality of life. The information provided is unregulated, but the Information Standard²¹ can offer a degree of quality control.

4.1.9 Communication and administrative support services

People with skin disease who are referred to specialist dermatology services need an efficient and easy-to-use patient-centred booking system. Any such system relies on services having strong administrative and secretarial support.

These support services are important to facilitate the good communication, which is particularly important with regard to shared care. There should be clear systems for managing and coordinating the patient's general medical care and, crucially, for preventing potentially adverse medication interactions, paying close attention to the detail of who is responsible for prescribing, dose adjustment and monitoring.

Patients should be offered a copy of their GP letter as established under the good practice guidelines published by the Department of Health in 2003.²²

Rationale

There is a duty on all healthcare professionals to communicate effectively and in a timely manner both with other healthcare professionals and with the patient.

Many systemic drugs used in patients with skin conditions are now prescribed on a shared care basis

4.2 Implications for commissioning

4.2.1

Commissioners should ensure that no patient is disadvantaged by restriction of access to accurate diagnosis and effective treatment.

4.2.2

Commissioners should ensure competent clinicians offer services in facilities that offer accessibility and privacy to those using the service and support patients to access all NICE-recommended treatments.

4.2.3

Commissioners should ensure that providers can supply evidence that policies, training and staff checks for safeguarding children and vulnerable adults are in place and current.

4.2.4

A system should be in place to audit treatment provision against national guidelines, including waiting times for treatment and patient experiences and outcomes.

4.2.5

Commissioners should always strive to use the available resources in the most cost-effective manner.

4.3 Key performance indicator

4.3.1

Adherence to current national and local guidelines.

4.4 References

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3. Department of Health (2009) *Reference Guide to Consent for Examination or Treatment, Second Edition*. Gateway reference 11911. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643)
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STANDARD 5

Models of care and links to other services

This standard explains the interrelationship between care pathways and links to the other services that a patient may need.

5.1 Recommendations

Note that a rationale (which may include background detail or further information) appears in italic type after each recommendation.

5.1.1 Models of care

Models of care for people with skin conditions should be developed to ensure that patients are seen by the right person, in the right place, at the right time and can move readily between the levels of care as necessary.

Consensus guidance, agreed by stakeholder commissioning groups (see 1.2.1), should be used to design services that are appropriate to the needs of the health community.

Rationale

Information about models of care and organisation of services has been developed and published by stakeholder groups representing patients, the public, doctors, nurses and pharmacists. Some examples are included in the list of further supporting documents at the end of this standard. These use available evidence and opinion about what works well for people with skin conditions, taking into account national guidance and policy statements.

The underpinning principle of all the guidance documents published in this area is that services should be integrated and are best designed by stakeholders based on a local assessment of need and using the commissioning cycle as a framework. Broad stakeholder engagement and enthusiastic clinical engagement by both GPs and dermatologists are essential for the success of this process.

5.1.2 Clinical links within dermatology

All services for people with skin conditions should be integrated, with established links to the local specialist services (Level 3) for advice, support and onward referral, irrespective of provider.

Where models of care include community-based specialist dermatology services, these should be closely linked to a specialist dermatology service (both Level 3) to enable patients to move seamlessly between services as determined by their clinical need.

Where skin surgery is offered in a community-based setting, there should be close formal links with a local specialist dermatology service and histopathology department (Level 3 or 4).

The local specialist service (Level 3) should have established links with regional and supra-specialist services (Level 4) for patients with rare and hard-to-treat skin conditions. Appendix E lists the range of Level 4 services to which good links should be identified so that patients can be referred readily between Level 3 and 4 services as appropriate.

There are important specific links for people with skin cancer.

Rationale

All healthcare professionals managing people with skin conditions have a responsibility to collaborate and co-operate in delivering services that are responsive to the people who access them and that offer high-quality care. It is expected that the local specialist dermatology provider (Level 3) will support Level 1 and Level 2 services and ensure that links are established with Level 4 services.

5.1.3 Care pathways between dermatology and other services

In addition to clinical links within the specialty of dermatology, all health communities should establish clear clinical care pathways between different services, irrespective of the provider of care. These should focus on ensuring appropriate clinical management for those people accessing services and should support healthcare professionals in delivering high-quality care. Such care pathways need to be clear, agreed and used by all service providers to ensure equity of access for all patients.

All local health economies should establish clear referral pathways with closely allied specialties and other relevant organisations and groups consistent with national guidance. Examples of such links are as follows (the list is not exhaustive):

- common specialties
 - plastic and reconstructive surgery
 - maxillo-facial surgery
 - paediatrics (in particular, due consideration should be given to the transition from children's services to adult dermatology services)
 - rheumatology
 - allergy specialists
 - tissue viability/skin integrity
 - podiatry
 - oncology and radiotherapy
 - ophthalmology
 - psychology
 - gynaecology
 - sexual health and HIV
- common groups and organisations
 - patient support groups and organisations
 - cancer support services

Rationale

Locally agreed clinical care pathways are essential to support equity of access to care, best clinical practice and optimum care outcomes. Agreed care pathways facilitate seamless care for people accessing services. Additionally, multidisciplinary and multi-professional working are recognised as key to providing good-quality care for people with complicated skin problems. The development of clear care pathways between specialisms supports optimal clinical care.

It is important that health communities maintain links with the relevant patient support groups and charities so that patients can benefit from all that these organisations offer. All healthcare professionals managing people with skin conditions should have a good understanding of and access to information about the voluntary patient groups that provide support and advice for patients on a range of care pathways.

5.1.4 Triage and referral management

Effective triage is important to ensure that patients are seen in a timely fashion by appropriately trained healthcare professionals. The following principles should underpin the development of processes of triage and referral management:

- Triage is best performed by suitably trained, experienced clinicians.
- Triage should be used to determine the priority of a patient's referral based on the severity and impact of their skin condition and to try to ensure that they are seen promptly by the most appropriate healthcare professional to manage their problem.
- Triage and referral management processes should not lengthen waiting times, should not be developed and implemented without clinical input and ongoing clinical support and should provide real diagnostic or treatment benefit for the patient.
- Good-quality digital images of skin lesions can be used to triage skin lesions and prioritise access to specialist services for the diagnosis and management of skin cancer.
- Patients with chronic skin conditions should be able to re-access services as necessary (for example, people with psoriasis requiring second-line treatments).
- Referral guidelines in relation to excluded treatments for the so-called 'low-priority conditions' (such as benign skin lesions) should be explicit and widely publicised.

Rationale

Triage and referral management are seen as important ways of managing demand for services in an environment of fixed and limited resources.

'Referral management' refers to any arrangements that create an intermediate level of triage, assessment and/or treatment between primary generalist (Level 2) care and specialist (Levels 3 and 4) care.¹ Referral management includes paper-based screening and its electronic equivalent. The aim is to reduce inappropriate referrals and redirect referrals so that more patients could be seen by the appropriate service.

Following triage in such a system, patients may be offered an appointment in an alternative service for assessment (often provided by a GPwSI) and possible treatment. The triage process is therefore important in ensuring that patients are seen in an appropriate setting.

There is a lack of good evidence of the effectiveness of referral management systems. As a result, guidance has been published about this.² Several of the statements in this section are based on this guidance.

The guidance makes clear that patients need to be fully informed of the service to which they are being referred and be offered choices of provider.

There are very few studies of referral management services in dermatology. One recent study of a specialist-led dermatology Clinical Assessment and Treatment Service (CATS) has shown that such services can work well for patients.³ It also highlighted certain important requirements to support high-quality care.⁴

- specialist clinicians performing the triage of referral letters
- experienced clinicians providing the services (a mix of consultant outreach, GPwSI, Associate Specialist⁵ and nurse specialist sessions)
- robust clinical governance frameworks

5.1.5 Cancer networks

All healthcare professionals managing people with skin cancer should have an identified role within the skin cancer network and, where required by NICE guidance, will be a member of a multidisciplinary team.⁶ This includes those working in intermediate or community dermatology services.

Rationale

The NICE guidance makes clear statements about the diagnosis and management of skin cancer and this has been updated to take account of the management of low-risk basal cell carcinomas in the community.⁷ Providers of care are assessed against the guidance by the process of cancer peer review.

5.1.6 Managed clinical networks (MCNs)

Health communities may wish to develop managed clinical networks (MCNs) similar to those developed in Scotland. These link groups of health professionals and organisations from primary and secondary care (Levels 2 to 4) and help them to co-ordinate their work across professional and geographical boundaries to ensure equitable provision of high-quality clinically effective services.

Rationale

An example of an MCN in Scotland is Photonet.⁸ Photonet provides a comprehensive high-quality service to patients requiring phototherapy services either as outpatients or inpatients across Scotland. Although the patients with the most complex needs will form a minority of those treated, the aim of the MCN is to ensure that the service facilitates the managed care of all patients, whatever the severity of the disease.

In England, the implementation of good practice guidance for conditions such as rare skin cancers is leading to the development of joined up networks of care between supra-specialist units and district general hospitals (Levels 3 and 4).

5.2 Implications for commissioning

5.2.1

Commissioners should consider how to incentivise service providers to ensure close and collaborative working and optimise clinical outcomes.

5.2.2

Commissioners should create and work with a stakeholder commissioning group to review and develop models of care and links between services, using the commissioning cycle and following examples from appropriate national guidance documents.⁹

5.2.3

Commissioners should ensure that care pathways are developed that are clear and appropriate to local needs and meet the holistic needs of each patient.

5.3 Key performance indicators

5.3.1

Compliance with NICE guidance and, in its absence, with acknowledged best practice and/or local guidance.

5.3.2

Evidence that a range of integrated services has been developed using consensus guidance.

5.3.3

Adherence to the NHS Act 2006 and the NHS Constitution.

5.4 References

1. Davies M and Elwyn G (2006) 'Referral Management Centres: Promising Innovations or Trojan Horses?' *BMJ* 332: 844-846.
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9. NHS Primary Care Contracting (2008) *Providing Care for Patients with Skin Conditions: Guidance and Resources for Commissioners*. Leeds: NHS Primary Care Contracting.

5.5 Further supporting documents and guidance

- All Party Parliamentary Group on Skin (2006) *Enquiry into the Adequacy and Equity of Dermatology Services in the United Kingdom*. London: All Party Parliamentary Group on Skin.
- Department of Health (2006) *Our Health Our Care, Our Say: A New Direction for Community Services*. Department of Health White Paper. Cm 6737. Norwich: The Stationery Office. (Brief guide available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127602)
- Department of Health (2007a) *Shifting Care Closer to Home: Care Closer to Home Demonstration Sites – Report of the Specialty Subgroups*. London: Department of Health. Gateway reference 8419. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079728)
- Department of Health (2007b) *Implementing Care Closer to Home: Convenient Quality Care for Patients* (in three parts). London: Department of Health. Part 1 and Overview available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074428)
- Department of Health (2008) *Manual for Cancer Services 2008: Skin Measures*. London: Department of Health.
- Dermatology Workforce Group (2007) *Models of Integrated Service Delivery in Dermatology*. London: The Dermatology Workforce Group.
- National Institute for Health and Clinical Excellence (2007) *Atopic Eczema in Children: Management of Atopic Eczema in Children from Birth up to the Age of 12 Years (NICE Clinical Guideline 57)*. London: National Institute for Health and Clinical Excellence. (Available at <http://guidance.nice.org.uk/CG57/Guidance/pdf/English>)
- NHS Modernisation Agency (2003) *Action on Dermatology - Good Practice Guide*. London: NHS Modernisation Agency. (Available at www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&products_id=218)
- NHS Modernisation Agency (2005) *Action on Plastic Surgery: The National Issue and Working Group Outputs. National Good Practice Guidance: Local Implementation Document 2*. London: NHS Modernisation Agency.
- NHS Primary Care Contracting (2008) *Providing Care for Patients with Skin Conditions: Guidance and Resources for Commissioners*. Leeds: NHS Primary Care Contracting. (Available at <http://www.evidence.nhs.uk/search?q=providing+care+for+patients+with+skin+conditions>)
- Skin Care Campaign (2006) *Referral Management Schemes (Tier 2 Clinical Assessment and Treatment Services): Implications for Dermatology Services*. London: Skin Care Campaign.

STANDARD 6

Diagnostic investigations

Diagnostic investigations are used frequently to diagnose skin conditions. This standard covers testing procedures and best practice.

6.1 Recommendations

Note that a rationale (which may include background detail or further information) appears in italic type after each recommendation.

6.1.1 Diagnostic investigations

Diagnostic investigations relevant to people with skin conditions include:

- blood tests for haematological, biochemical, immunological or microbiological investigations
- tissue specimens for microbiological or histopathological testing
- pregnancy tests and skin scrapings carried out at point of care
- patch tests and prick tests
- phototesting and photopatch testing
- radiological investigations

All tests should be requested by a person trained to instigate appropriate investigation.

Pathology specimens should be obtained by staff who have been trained to take specimens and manage them appropriately, taking into account health and safety issues.

All lesions removed from patients should be submitted for histopathological investigation.¹

Point-of-care tests include pregnancy testing and examination of skin scrapings for yeast or fungi or for mites. These tests should be performed using a reliable method by someone who is appropriately trained. Results should be recorded in the patient's notes.

Specimens should be transported in appropriate containers with patient's details and clinical information meeting the laboratory's minimum acceptance criteria.

Patch tests should be performed in accordance with national guidance.²

The person requesting a radiological investigation should document in the patient's notes the reason the test was requested and the clinical decision to be made in response to the result.³

Rationale

Pregnancy tests may be carried out as part of pregnancy prevention programmes related to certain dermatology treatments (eg for patients taking retinoids).⁴ They should be carried out according to an approved standard operating procedure by a person trained and certified to do so, as specified in the Medicines and Healthcare Products Regulatory Agency (MHRA) guidelines on in vitro diagnostic (IVD) point-of-care test devices.⁵ Results should be documented in the patient's clinical records and the person carrying out the test identified.

Exposure to X-rays carries a risk of inducing malignancy, so radiological investigation should be undertaken only when the results may affect clinical management.

6.1.2 Laboratory standards

The laboratory must be appropriately accredited with a nationally approved scheme, such as Clinical Pathology Accreditation (CPA UK) Ltd (now part of the United Kingdom Accreditation Service (UKAS)), and be seen to comply with the international standards for medical laboratory accreditation, ISO 15189.

The laboratory must participate in accredited technical and medical external quality assessment schemes (EQAS) and be able to demonstrate satisfactory performance against the defined criteria.

NICE guidance makes clear that cancer networks should establish two levels of multidisciplinary teams – local hospital skin cancer multidisciplinary teams (LSMDTs) and specialist skin cancer multidisciplinary teams (SSMDTs). All health professionals who knowingly treat patients with any type of skin cancer should be members of one of these teams, whether they work in the community or in the hospital setting. The Tumour Site Specific Group (TSSG) for skin cancer, a group of clinicians from a geographic region who establish standards for treatment and diagnosis, should agree network-wide pathology guidelines for the diagnosis of skin cancers. The guidelines should address laboratory and histopathology/histochemical investigations and their specific indications and follow Royal College of Pathologist guidelines for reporting skin cancer.⁶ The laboratory should use National Standard Methods⁷ where available.

Rationale

Clinical Pathology Accreditation (CPA) ensures that laboratories have a quality and audit system in place and is the standard by which UK diagnostic laboratories work. There are regular, rigorous and ongoing assessments to ensure this quality is maintained. A list of accredited laboratories and their current status can be obtained from www.cpa-uk.co.uk.

The National Standard Methods is a comprehensive referenced collection of clinical microbiology standard operating procedures, algorithms and guidance notes.² It is designed to ensure that laboratories provide a good clinical and public health microbiology service and to increase standardisation of methods across the labs.

External quality assurance, as provided, for example, by the UK National External Quality Assessment Service (www.ukneqas.org.uk) or Quality Control for Molecular Diagnostics (www.qcmd.org), is a requirement of CPA. It is used to give external quality assessment in laboratory medicine, to promote best practice and ensure the results of investigations are reliable and comparable.

6.1.3 Reviewing and reporting skin biopsies

Consultant pathologists reporting skin biopsies should undertake yearly external quality assessment (EQA) activities. These should involve general EQA with a significant skin component or be part of a specialist skin EQA schemes.⁸

Rationale

Clinicians need to ensure that the quality of reporting is maintained at the required standard – this will become part of revalidation in the future.

6.1.4 Laboratory turnaround times

The time from specimen-taking to the clinician receiving the report should, wherever possible, be seven working days or less.⁹ The turnaround time for laboratory testing and reporting, therefore, should be five working days or less.

If supplementary testing or referral to the reference laboratory is necessary, then a preliminary report should be issued and the final report received within 14 days.

Electronic requesting and reporting should be encouraged in order to minimise turnaround times.

Rationale

The turnaround time for a test result includes the time taken for the specimen to reach the laboratory, for performing and reporting the test and delivery of the result report to the clinician. Attention should be given to all aspects of this process to provide timely results for the service user. It is important that the laboratory has sufficient workload to ensure frequent testing (more than once a week).

6.1.5 Reporting test results

Management and reporting of laboratory test results, including validating, authorising and relaying a result, must be performed by a healthcare professional (such as a biomedical scientist or clinical scientist) with a current Health Professional Council (HPC) registration.

Expert advice on the management of clinical care arising from the laboratory test result must be given only by a medically qualified microbiologist, pathologist or a clinical scientist of consultant standing.

In the case of a skin biopsy specimen for histopathological diagnosis, the result should be reported and expert advice given by a consultant histopathologist on the GMC specialist register or a dermatopathologist holding the Diploma in Dermatopathology or the equivalent.

Rationale

The Health Professions Council regulates health professionals using a series of standards for their training, competence, professional skills, behaviour and health. Registration is mandatory for laboratory personnel involved in the validation and authorisation of test reports. A list of registrants is available at www.hpc-uk.org.

There is a need for national guidance on a range of the more specialist and supra-specialist dermatology investigations that are outwith the scope of this document.

6.2 Implications for commissioning

6.2.1

Dermatology services should have access to all forms of pathology services and commissioners should ensure that pathways are in place for taking, transporting and processing specimens, and for viewing and acting on the results.

6.2.2

All laboratories commissioned to perform diagnostic testing should be appropriately accredited and deliver optimal standards of laboratory services. They should have evidence of external quality assessment (EQA), internal quality control (IQC) and internal quality assurance (IQA).

6.2.3

Commissioners should ensure there is continuity planning provision should the contracted laboratory be unable to provide the service.

6.2.4

Economies of scale may be identified through regional commissioning of services.

6.2.5

Commissioners should ensure that specialised dermatology investigations (eg patch testing) are available for patients and are carried out and interpreted by trained staff in a safe environment.

6.3 Key performance indicators

6.3.1

Percentage of preliminary reports that are received by clinicians within seven working days of a specimen being taken. (standard 100%)

6.4 References

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2. Bourke J, Coulson and English J (2009) 'Guidelines for the Management of Contact Dermatitis: An Update' *British Journal of Dermatology* (160): 946-954.
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5. Medicines and Healthcare Products Regulatory Agency (MHRA) *Management and Use of IVD Point of Care Test Devices - DB2010(02)*. (Available at www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON071082)
6. NHS National Action Cancer Team (2008) *National Cancer Peer Review Programme. Manual for Cancer Services 2008: Skin Measures*. Gateway reference: 10790. (Available at www.dh.gov.uk/en/Healthcare/Cancer/Treatment/DH_101998)
7. Health Protection Agency National Standard Methods. (Available at www.hpa-standardmethods.org.uk)
8. UK National External Quality Assurance Service (www.ukneqas.org.uk), Quality Control for Molecular Diagnostics (www.qcmd.org), Health Professions Council (www.hpc-uk.org).
9. NHS Service Improvement (2010) *Learning How to Achieve a Seven Day Turnaround Time in Histopathology*. Gateway reference 150009. (Available at <http://www.improvement.nhs.uk/diagnostics/PathologyNewsandEvents/PreviousPathologyNews/tabid/108/Default.aspx>)

STANDARD 7

Clinical governance

This standard recommends ways to provide the safest and most effective care.

7.1 Recommendations

Note that a rationale (which may include background detail and further information) appears in italic type after each recommendation.

7.1.1 Clinical effectiveness

Clinical governance should be embedded in the clinical practice of all services in order to standardise and constantly improve clinical effectiveness.

All specialist services should audit their clinical effectiveness alongside ongoing reviews of safety and patient experience, following the specific guidance for their specialty.¹

Rationale

Public trust in the NHS is conditional on the NHS's ability to keep patients safe.

High Quality Care for All² makes clear that patient safety should be top of the healthcare agenda for the 21st century, while Liberating the NHS³ stresses the importance of measuring healthcare outcomes against quality standards.

7.1.2 Clinical leadership

Specialist services for people with skin conditions (those led by consultants on the specialist register of the GMC for dermatology) should provide clinical leadership, including supervision, training, clinical expertise, clinical management and research into skin conditions, within local health communities.

It is important that all providers of services for people with skin conditions have robust links with the local specialist dermatology service and have a nominated clinical governance lead to facilitate this. This post will have responsibility for overseeing and ensuring the clinical quality of the service delivered.

Supra-specialist (Level 4) services should provide similar clinical leadership for their specific services and wider community.

Rationale

Clinical leadership is fundamental to creating an environment in which clinical effectiveness can flourish.

The specialist dermatology service as a whole (Level 3) is vital in supporting teaching and training (but not necessarily delivering it themselves). This is set out in more detail in Standard 3.

7.1.3 Use of information and information technology

Information technology should be developed and used to support clinical governance within and across organisations by supporting clinical and data reporting requirements.

A diagnostic database and clinical information system are important requirements to support the clinical effectiveness of services.

The keeping of medical records and documentation as per the current guidelines^{4, 5} is a crucial part of clinical governance. For more information on the appropriate use and processing of high-quality patient data and the need to maintain confidentiality see Standard 8 on information governance.

Rationale

Standardisation of clinical governance requirements across providers will help to ensure safe, equitable delivery of services, regardless of who provides them. Integrated IT systems that meet information governance standards and facilitate the sharing of data where appropriate (see Standard 8) can support this and their development should be encouraged.

7.1.4 Education, training and continuing professional development (CPD)

It is essential that all providers of care for people with skin conditions are appropriately trained and competent to deliver care (see Standard 3 for further details on this).

Specialist providers of dermatology care should support the provision of training for the management of the full range of skin conditions.

All specialist providers of services for people with skin conditions should have a clear framework for education, training and continuing professional development (CPD) that includes mentorship, clinical supervision, case note review (where appropriate) and assessment of development and ongoing competence. This will support Standard 3, which makes a number of recommendations relating to appropriately trained staff.

Rationale

Anyone accessing services should have their care provided by an appropriately trained healthcare professional. Teaching and training are central to any governance structure.

Medical professionals should undertake and be supported in CPD in their specialty. This can be assessed externally through appraisal and peer review.

7.1.5 Clinical audit

All specialist providers of services for people with skin conditions should, as a minimum, audit annually elements of clinical practice against current local and national guidelines and evidence-based pathways and procedures.

A list of guidance relevant to skin conditions from the National Institute of Health and Clinical Excellence is included at Appendix F.

Within clinical networks, particularly skin cancer networks, audit outcomes should be used to evaluate care pathways, monitor the quality of clinical activity and make changes as necessary to optimise care.

Rationale

Audit is an important part of clinical governance. Setting standards of care (locally and/or nationally) and auditing against them, helps services to systematically review processes and clinical outcomes, so they can implement change where it is most needed – and measure its effects.

A basic audit programme covering the minimum requirements for a Level 3 specialist service is included in Appendix F.

7.1.6 Risk management

All providers of services for people with skin conditions should have procedures in place to minimise risk to both service users and staff.

All services should be compliant with local and national requirements.

Clear mechanisms should be in place to report, review and respond formally to all clinical incidents and complaints using, for example:

- incident and near-miss recording, with investigation and root cause analysis⁶
- audit of current practices and standards and of medical records

Rationale

Managing risk is a growing challenge in an increasingly litigation-conscious healthcare climate.

Robust organisational arrangements for managing risk, including critical incidents and complaints, should be a priority.⁷ Transparency and sharing of incidents is likely to lead to collective learning and improvement in patient care.

7.1.7 Patient experience and involvement

Services should, as a minimum, gather patient-recorded experience measures (PREMs) annually. The results should be shared and any actions agreed. Patient (and public) involvement in service development and feedback on patient experience is covered in detail in Standard 2.

Rationale

Methods for involving patients and in particular for gathering information on their experience of the service are discussed in Standard 2.

7.2 Implications for commissioning

7.2.1

Commissioners should ensure that requirements for clinical governance and accountability are explicit in all contracts with providers of dermatology services. Stakeholder commissioning groups provide the opportunity to develop these standards.

7.2.2

Commissioners should enable an effective integrated clinical governance system that complies with agreed performance levels identified within service specifications. It should also comply with Care Quality Commission requirements.

7.2.3

Commissioners should ensure that audit requirements relating to the management of people with skin conditions (reflecting local and national guidance) are specific in all contracts and are monitored. They should require an annual audit report from providers.

7.3 Key performance indicators

7.3.1

Audit:

Providers of services for people with skin conditions should be able to demonstrate:

- a named identified clinical governance lead
- evidence of annual participation in local, regional and national audit programmes and completion of an annual audit plan with guidelines and protocols as appropriate (for an example of the annual audit requirements for a dermatology department, see Appendix E)
- evidence that healthcare professionals meet all the statutory requirements to practise, including any in respect of continuing professional development (for more detail see Standard 3)
- documented evidence that facilities meet agreed national standards

7.3.2

Patient-recorded experience measures (PREMs), as described in Standard 2.
(Standard: over 90% positive patient experience.)

7.4 References

1. Royal College of Physicians (2008) 'Dermatology' pp. 122—124 in *Consultant Physicians Working with Patients*. London: Royal College of Physicians.
2. Department of Health (2008) *High Quality Care for All: NHS Next Stage Review Final Report*. Department of Health White Paper. Gateway reference 10106. Cm 7432. Norwich: The Stationery Office. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)
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5. Department of Health (2006) *Records Management: NHS Code of Practice Part 1: For the Functional and Operational Management of Clinical Records*. Gateway reference 6295. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747)
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7.5 Further supporting documents and guidance

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Children Act 2004. London: The Stationery Office. (Available at <http://www.legislation.gov.uk/ukpga/2004/31/contents>)

Department of Health (2001) *Building A Safer NHS for Patients: Implementing an Organisation with a Memory*. London: Department of Health. Gateway reference 23720. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006525)

Department of Health (2004) *Standards for Better Health*. London: Department of Health. Gateway reference 3528 (updated version 6405). (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665)

Mental Capacity Act 2005. London: The Stationery Office. Available at www.legislation.gov.uk/ukpga/2005/9/contents)

National Institute for Health and Clinical Excellence (2006) *Guidance on Cancer Services: improving Outcomes for People with Skin Tumours including Melanoma: The Manual*. London: National Institute for Health and Clinical Excellence. (Available at www.nice.org.uk/nicemedia/live/10901/28906/28906.pdf)

National Institute for Health and Clinical Excellence (2007) *Atopic Eczema in Children: Management of Atopic Eczema in Children from Birth up to the Age of 12 Years (NICE Clinical Guideline 57)*. London: National Institute for Health and Clinical Excellence. (Available at <http://guidance.nice.org.uk/CG57>)

STANDARD 8

Information governance

This standard explains how to handle ‘information in a confidential and secure manner to appropriate ethical and quality standards’.¹

8.1 Recommendations

Note that a rationale (which may include further detail and background information) appears in italic type after each recommendation.

8.1.1 Personal data

‘Personal data’ can be taken here to mean generally (but not exclusively) the information held in patient notes.

Dermatology services need to hold personal data, which may include printed or digital images such as those used in teledermatology, about patients.

A clear policy of information governance is legally essential to ensure that information about patients is safeguarded and is used appropriately.

Rationale

Personal data is defined as data relating to a living individual that enables him or her to be identified.²

Information about a patient may be needed³ to support a range of important areas, in particular

- *continuity of patient care*
- *the delivery of evidence-based care*
- *clinical governance*
- *development of patient services*

or to meet legal requirements (including requests from patients under the provisions of the Freedom of Information Acts^{4, 5}) or assist in auditing services.

Information governance has four main components:⁶

- *information governance management,*
- *confidentiality and data protection assurance*
- *information security assurance*
- *information quality assurance*

8.1.2 Data quality

Information should be collected and recorded in accordance with published quality standards.^{7, 8, 9}

Rationale

Good quality data is:

- *accurate*
- *recorded as soon as practicable and made available as soon after the event as possible*
- *valid - the use of any codes should map to national values and comply with national standards*
- *complete - mandatory data items within a data set should be populated*
- *consistent*
- *available to enable response to issues*

Record-keeping standards have been developed by professional bodies⁹ and the NHS.^{3, 10}

The NHS Data Model and Dictionary⁷ provides a reference point for assured information standards to support health care activities within the NHS in England. All changes are assured by the Information Standards Board for Health and Social Care.⁸

8.1.3 Confidentiality and data processing

Data should be obtained, recorded, held, altered, retrieved, transferred, destroyed or disclosed in accordance with the Common Law Duty of Confidentiality,¹¹ Caldicott Guidance,¹² the Data Protection Act(1998)² and other national and professional guidelines.

Rationale

Healthcare professionals have a duty of confidentiality to their patients.^{13, 14, 15}

The Data Protection Act (1998)² regulates the processing of personal data. This applies to both paper and electronic records, including photographs, which are commonly used in dermatology as a means of recording the skin. 'Processing' means obtaining, recording, holding, altering, retrieving destroying or disclosing data.

All NHS records are public records under the Public Records Act 1958.¹⁶ Records should generally be kept for the minimum period necessary, whether this is to meet any statutory requirement^{10, 17} or for administrative purposes.

The Caldicott Principles¹² were developed to provide a framework of good practice in the use of patient information for NHS staff. These principles dictate the transfer of information between partner agencies and define circumstances of appropriate disclosure.⁶

Confidential information should be transferred to 'safe havens',¹⁸ where information can be received and stored in a secure manner.

The NHS Information Governance Toolkit provides guidance for organisations. The Toolkit return is required from any organisation requesting access to NHS Connecting for Health's digital information services.¹⁹

Every organisation is required to have a Senior Information Risk Owner.²⁰

8.1.4 Information for patients

All patients should have access to information about how their data is being used and safeguarded.

Rationale

All service providers should have clear and transparent information available to people using services about how to request access to their own health records.⁷

It is the responsibility of every healthcare professional to ensure that each patient knows exactly:

- *what information is being kept about them*
- *how to access this*
- *how to challenge any information that has been kept and or shared about them*

8.2 Implications for commissioning

8.2.1

Commissioners must ensure that all providers of services managing patients with skin conditions comply with national guidelines and legal requirements in relation to the recording, storing, transferring and processing of data, particularly images.²¹ Providers of all services managing patients should be registered under the Data Protection Act and have an information governance system in place.

8.2.2

Commissioners need a clear understanding of the core requirements for national data reporting to help them in developing a minimum dataset and any supplementary local data recording requirements.

8.2.3

Commissioners need to ensure that all providers of services managing patients with skin conditions can securely transmit datasets to relevant third parties and are able to provide adequate security measures to protect the anonymity of service users and comply with the Data Protection Act and the Caldicott Principles.

8.3 Key performance indicators

8.3.1

Service providers are registered with the Information Commissioner for data processing. (Standard: 100%)

8.3.2

Service providers have an information governance policy in place to ensure legal and national guidelines are followed. (Standard 100%)

8.4 References

1. NHS Connecting for Health (nd) *The Information Governance Assurance Programme and Framework*. (Available at www.connectingforhealth.nhs.uk/systemsandservices/infogov/igap)
2. The Data Protection Act 1998. London: The Stationery Office. (Available at www.legislation.gov.uk/ukpga/1998/29/contents)
3. Department of Health (2006) *Records Management: NHS Code of Practice Part 1: For the Functional and Operational Management of Clinical Records*. Gateway reference 6295. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747)
4. Freedom of Information Act 2000. London: The Stationery Office. (Available at www.legislation.gov.uk/ukpga/2000/36/contents)
5. Freedom of Information (Scotland) Act 2002. London: The Stationery Office. (Available at www.legislation.gov.uk/asp/2002/13/contents)
6. Department of Health (2010) *Caldicott Guardian Manual 2010*. Gateway reference 14043. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114509)
7. NHS Connecting for Health (nd) *NHS Data Model and Dictionary*. (Available at www.datadictionary.nhs.uk)
8. Information Standards Board for Health and Social Care (nd) *Information Governance*. (Available at www.isb.nhs.uk/use/baselines/ig)
9. Royal College of Physicians (nd) *Standards for Medical Record Keeping*. (Available at www.rcplondon.ac.uk/resources/clinical/medical-record-keeping)
10. Department of Health (2006) *Records Management: NHS Code of Practice Part 2: For Record Retention Periods*. Gateway reference 10678. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747)
11. Department of Health (2007) *NHS Information Governance: Guidance on Legal and Professional Obligations*. London: Department of Health. Gateway reference 8523. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079616)
12. Department of Health (1997) *The Caldicott Committee Report on the Review of Patient-identifiable Information (The Caldicott Report)*. Gateway reference 1997. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4068403)
13. Royal College of Nursing (2006) *Competencies: An Integrated Career and Competency Framework for Information Sharing in Nursing Practice*. London: Royal College of Nursing
14. Medical Protection Society (2010) *MPS Guide to Medical Records*. (Available at www.medicalprotection.org/uk/booklets/MPS-guide-to-medical-records)
15. General Medical Council (2009) *Confidentiality*. London: General Medical Council. (Available at http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp)
16. Public Records Act 1958. London: The Stationery Office. (Available at www.legislation.gov.uk/ukpga/Eliz2/6-7/51)
17. The Royal College of Pathologists (2005) *The Retention and Storage of Pathological Records and Archives*. (Available at www.rcpath.org/index.asp?PageID=38#general)
18. NHS Connecting for Health (nd) *Safe Haven* (download). (Available at www.connectingforhealth.nhs.uk/systemsandservices/infogov/igworkshops/safehaven)
19. NHS Information Governance (nd) *The NHS Information Governance Toolkit*. (Available at www.igt.connectingforhealth.nhs.uk)
20. NHS Connecting for Health (nd) *Role of Senior Information Risk Owner*. (Available at www.connectingforhealth.nhs.uk/systemsandservices/infogov/security/risk/nhsinforiskmgt)
21. General Medical Council (2011) *Making and Using Visual and Audio Recordings of Patients*. London: General Medical Council. (Available at www.gmc-uk.org/guidance/ethical_guidance.asp)

8.5 Further supporting documents and guidance

British Medical Association (2009) *Confidentiality and Disclosure of Health Information Tool Kit*. London: British Medical Association. (Available at www.bma.org.uk/ethics/confidentiality/confidentialitytoolkit.jsp)

Children Act 2004. London: The Stationery Office. (Available at www.legislation.gov.uk/ukpga/2004/31/contents)

Department of Health (2003) *Confidentiality: NHS Code of Practice*. Gateway reference 2003. (Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253)

Health and Social Care Act 2001. London: The Stationery Office. (Available at www.legislation.gov.uk/ukpga/2001/15/contents)

NHS Scotland (nd) *Information Governance in Scotland: A Competency Framework*. (Available at www.nes.scot.nhs.uk/about-nes/publications/information-governance-in-nhsscotlanda-competency-framework)

THE APPENDICES



APPENDIX A

Membership of the project groups

Project working group

Name	Role	Organisation/Region
Janet McLelland	Project lead, Consultant Dermatologist	BAD
Carol Blow	GP	RCGP
Helen Frow	GPwSI	PCDS
Andrew Langford	Chief Executive	Skin Care Campaign
Rebecca Penzer	Dermatology Specialist Nurse	Norfolk
Julia Schofield	Consultant Dermatologist	Lincolnshire

Project advisory group

Name	Role	Organisation/Region
Hilary Benbow	Associate Specialist/GP	Newcastle
Mary Carr	Consultant Dermatologist	Durham
Margaret Cox	Chief Executive	National Eczema Society
Tim Cunliffe	GPwSI	PCDS
Stephen Foster	National Clinical Lead	Pharmacy
Akhtar Husain	Pathologist	Newcastle
Stephen Kownacki	GP	PCDS
Sue Lewis-Jones	Consultant Dermatologist	Scotland
Stephen Lock	Senior Policy Manager	DH
Helen McAteer	Chief Executive	Psoriasis Association
Pamela McHenry	Consultant Dermatologist	BSPD
Kevin McKenna	Consultant Dermatologist	Northern Ireland
Martin McShane	Director of Strategic Planning and Health Outcomes	NHS Lincolnshire
Liz Parrish	Dermatology Clinical Nurse Specialist	BDNG
Mandy Platts	GP	RCGP
Sofina Taj	Prescribing Advisor	Peterborough
Richard Williams	Consultant Dermatologist	Wales

APPENDIX B

Levels of care for skin conditions in the UK

The following list briefly describes the four levels of care for patients with skin conditions as they operate in the UK.

From Level 2 onwards there should be a care pathway in place for referral if the condition is beyond the scope or competence of the original service. Formal links are recommended between GPs at Level 2 and clinical specialists at Level 3, as described in Standard 5.

Level 1: Self-care/self-management

This level covers people with mild and manageable skin conditions (which may or may not be chronic).

Self-care

These people will generally be able to manage their condition themselves or have it managed by friends and family. Care is mainly in the form of information and advice from sources such as:

- local community pharmacists
- patient groups
- the general media
- the internet

Self-management

People who consult a healthcare professional for advice are then able to use the self-management information/plan to manage their skin condition without any further direct input from a healthcare professional at this stage.

For people who do go on to other levels, self-management will be an integral part of the care pathway they follow in collaboration with the services they use.

People at Level 1 progress to Level 2 by visiting a local healthcare facility, such as their GP for diagnosis and/or advice.

Level 2: Generalist (or primary) care

Anyone experiencing a skin problem goes to Level 2 when they visit:

- their GP
- practice nurse

In some cases they may see:

- a community dermatology nurse
- pharmacist with special training in skin problems.

At Level 2 the GP acts as gatekeeper, referring people on to Level 3 if necessary, using liaison services, teledermatology and referral management.

Level 3 Intermediate and specialist care

Intermediate care

(also known as tier 2 services, clinical assessment and treatment services (CATS))

Intermediate care is usually delivered by specialist outreach services, ie:

- consultant dermatologists
- SAS doctors
- dermatology specialist nurses

And by:

- accredited GPwSIs

And in some cases by:

- accredited PhwSIs

Intermediate care is most often delivered at a community healthcare facility, but can also be delivered in an acute hospital if this is more convenient for the patient.

Specialist care

(also known as secondary care)

Specialist care is delivered by:

- consultant dermatologists
- specialist registrars
- SAS doctors
- Trust grade doctors
- clinical assistants
- hospital practitioners
- dermatology specialist nurses
- accredited or training GPwSIs

All patients in specialist care will attend a hospital-based dermatology service or a community health facility suitable for specialist care.

Level 4: Supra-specialist or regional care (also known as tertiary care)

Level 4 care usually takes place entirely within an acute hospital and is carried out by:

- consultant dermatologists
- a range of other healthcare professionals with special skills in the management of complex and/or rare skin disorders.

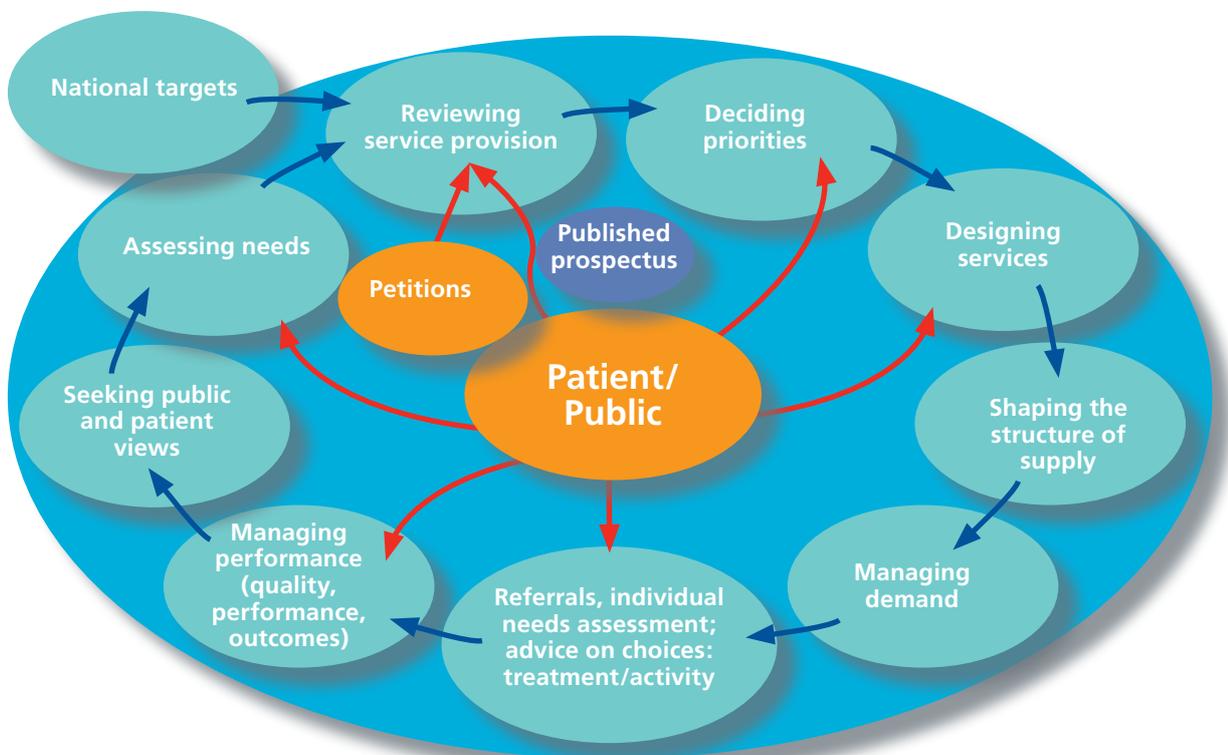
Source: adapted from Schofield J.K. & Williams H.C. (2009) *Skin Conditions in the UK: A Health Care Needs Assessment*, Nottingham: Centre of Evidence Based Dermatology (www.nottingham.ac.uk/scs/documents/documentsdivision/documentsdermatology/hcnaskinconditionsuk2009.pdf)

APPENDIX C

The commissioning cycle

Figure 1:

The commissioning cycle (from: Health reform in England: update and commissioning framework:annex - the commissioning framework Department of Health 2006)



APPENDIX D

Dermatology education and training matrix – current requirements

Professional group	Levels at which care is provided	Required dermatology training/education/competences/ qualifications	CPD/ongoing dermatology practice requirements
Healthcare support workers/ assistants	2, 3, 4	No standardised requirements	None
General registered nurses (including practice nurses, community nurses and nurse practitioners)	2, 3	None	All nurses: To maintain registration with the Nursing and Midwifery Council nurses are required to complete 35 hours of learning activity (Continuing Professional Development) in the previous three years.
Specialist registered nurses <ul style="list-style-type: none"> • hospital based • community based 	3, 4 2, 3	Various post-qualifying training – not standardised. Guidance documents: <i>The Integrated Career and Competency Framework</i> (Royal College of Nursing and British Dermatological Nursing Group 2005) <i>RCN Competences: An Education and Training Framework for Paediatric Dermatological Nursing</i> (Royal College of Nursing 2009)	There is no specific requirement for this to be dermatology learning activity, but it would be expected that this would be the case for specialist nurses working in dermatology. For general nurses, this CPD allocation is likely to cover a broad range of areas.

Professional group	Levels at which care is provided	Required dermatology training/education/competences/ qualifications	CPD/ongoing dermatology practice requirements
GPs	2	<p>Undergraduate medical training:</p> <p>No formal requirement for any undergraduate training in dermatology. Limited ad hoc assessment as part of general medical training but no formal requirement for students to be assessed as competent in the management of skin conditions.</p> <p>New dermatology curriculum circulated to all medical schools in 2006 (British Association of Dermatologists 2006). Minimum of 2 weeks training recommended.</p> <p>Postgraduate GP training:</p> <p>Skin problems are one of a number of curriculum areas which it is anticipated that general practitioner specialist registrars will complete as part of their specialist training to become a GP. Limited formal assessment of competency (Royal College of General Practitioners 2005).</p>	None currently other than revalidation and relicensing requirements.
GPs performing skin surgery (including low-risk BCCs)	2, 3	<p>GPs performing skin surgery are expected to have demonstrated their competency via a Direct Observation of Procedural Skills (DOPS) and/or the performance of regular skin surgery.</p> <p>Guidance is contained in:</p> <p><i>Revised Guidance and Competences for the Provision of Services using GPs with Special Interests (GPwSI). Dermatology and Skin Surgery (DH 2011)</i></p>	<p>Information about ongoing CPD and demonstration of competency is contained in:</p> <p><i>Revised Guidance and Competences for the Provision of Services using GPs with Special Interests (GPwSI). Dermatology and Skin Surgery (DH 2011)</i></p>

Professional group	Levels at which care is provided	Required dermatology training/education/competences/ qualifications	CPD/ongoing dermatology practice requirements
		<p>Further guidance is contained in:</p> <p><i>Improving Outcomes for People with Skin Tumours Including Melanoma (update). The Management of Low-risk Basal Cell Carcinomas in the Community (NICE 2010)</i></p>	<p>And</p> <p><i>Improving Outcomes for People with Skin Tumours Including Melanoma (update). The Management of Low-risk Basal Cell Carcinomas in the Community (NICE 2010)</i></p>
Pharmacists	1, 2	No standardised requirement, training optional.	CPD requirements of the pharmacists professional body, 9 CPD entries per year related to clinical pharmacy practice.
General Practitioner with a Special Interest (GPwSI)	2, 3	<p>A generic framework for the accreditation of all GPwSI, whatever the specialty, sits within the guidance for commissioners entitled:</p> <p><i>Implementing Care Closer to Home: Convenient Quality Care for Patients Parts 1-3 (DH 2007)</i></p> <p>Specialty specific guidance is available in:</p> <p><i>Revised Guidance and Competences for the Provision of Services using GPs with Special Interests (GPwSI). Dermatology and Skin Surgery (DH 2011)</i></p> <p>Competences required and assessment tools are contained within the specialty specific guidance.</p> <p>Further guidance is contained in:</p> <p><i>Improving Outcomes for People with Skin Tumours Including Melanoma (update). The Management of Low-risk Basal Cell Carcinomas in the Community (NICE 2010)</i></p>	<p>The requirements for ongoing professional development and mentoring are listed in:</p> <p><i>Revised Guidance and Competences for the Provision of Services using GPs with Special Interests (GPwSI). Dermatology and Skin Surgery (DH 2011)</i></p> <p>And</p> <p><i>Improving Outcomes for People with Skin Tumours Including Melanoma (update). The Management of Low-risk Basal Cell Carcinomas in the Community (NICE 2010)</i></p>

Professional group	Levels at which care is provided	Required dermatology training/education/competences/ qualifications	CPD/ongoing dermatology practice requirements
Pharmacists with a Special Interest in People with Skin Conditions (PhwSI)	1, 2, 3	<p>The principles for the accreditation of PhwSI sits within the guidance for commissioners entitled:</p> <p><i>Implementing Care Closer to Home: Convenient Quality Care for Patients Parts 1-3</i> (DH 2007)</p> <p>Specific guidance is contained in:</p> <p><i>Guidance and Competences for the Provision of Services using Pharmacists with Special Interests (PhwSI): People with Skin Conditions</i> (DH 2009)</p>	<p>The document entitled:</p> <p><i>Guidance and Competences for the Provision of Services using Pharmacists with Special Interests (PhwSI): People with Skin Conditions</i> (DH 2009) states the requirements for ongoing professional development and mentoring.</p>
SAS doctors	3, (4)	<p>To become an SAS doctor* you must have 4 years' post-graduate training, 2 of these in the specialty. This group of doctors works in a supervised environment with consultant dermatologist clinical leadership and mentoring. SAS doctors can apply for a Certificate of Eligibility for Specialist Registration (CESR), in which case they are required to demonstrate knowledge and experience equivalent to that of a consultant with a Certificate of Completion of Training (CCT). If successful the candidate can then be admitted to the General Medical Council Specialist Register and become eligible to apply for a definitive consultant appointment.</p>	<p>Annual appraisal with identification of learning needs.</p> <p>Revalidation and relicensing requirements.</p>

Professional group	Levels at which care is provided	Required dermatology training/education/competences/ qualifications	CPD/ongoing dermatology practice requirements
Consultant dermatologists (general)	3, 4	<p>Formalised training programme including training in General Medicine, with a requirement to pass the Membership of the Royal College of Physicians (MRCP) examination, four year specialist training in Dermatology leading to Certificate of Completion of Training (CCT). This replaced the Certificate of Completion of Specialist Training (CCST) in 2005. The two are equivalent and are a pre-requisite for appearing on the Specialist Register of Dermatologists in the UK.</p> <p>Those working in regional/ supra-specialist services will have additional training in these areas.</p>	<p>Revalidation and relicensing.</p> <p>Annual appraisal incorporating evidence of 360-degree multi-source feedback, clinical audit and continuing professional development needs as required by the Royal College of Physicians.</p>

Note*

SAS doctors currently include Associate Specialists, who have at least 10 years postgraduate experience (at least two in dermatology) and staff grade doctors who must have at least three years postgraduate experience. All new entrants to the grade, however, are specialty doctors – their requirements are set out in the table.

Useful references and guidance documents

British Association of Dermatologists (2006) *Dermatology in the Undergraduate Medical Curriculum: Recommendations of the British Association of Dermatologists*. London: British Association of Dermatologists.

Department of Health (2007) *Implementing Care Closer to Home: Convenient Quality Care for Patients (in three parts)*. London: Department of Health.

Department of Health (2007) *Implementing Care Closer to Home: Convenient Quality Care for Patients: A National Framework for Pharmacists with Special Interests*. London: Department of Health. Gateway reference 696

Department of Health (2009) *Guidance and Competences for the Provision of Services using Pharmacists with Special Interests (PhwSI): People with Skin Conditions*. London: Department of Health.

Department of Health (2011) *Revised Guidance and Competencies for the Provision of Services using GPs with Special Interest (GPwSI): Dermatology and Skin Surgery*. London: Department of Health. (Available at <http://gp.dh.gov.uk/2011/04/15/revised-guidance-on-gp-wsi-dermatology-and-skin-surgery-services/>)

National Institute for Health and Clinical Excellence (2010) *Improving Outcomes for People with Skin Tumours including Melanoma (update): The Management of Low-risk Basal Cell Carcinomas in the Community (partial guidance update)*. London: National Institute for Health and Clinical Excellence. (Available at www.nice.org.uk/nicemedia/live/10901/48878/48878.pdf)

Royal College of General Practitioners (2005) *Curriculum Map. Skin Problems 15.10* <http://www.rcgp-curriculum.org.uk/extras/curriculum/index.aspx> London: Royal College of General Practitioners.

Royal College of Nursing and British Dermatological Nursing Group (2005) *Competencies: An Integrated Career and Competency Framework for Dermatology Nursing*. London: Royal College of Nursing.

Royal College of Nursing (2009) *RCN Competences: An Education and Training Framework for Paediatric Dermatological Nursing* London: Royal College of Nursing.

Schofield JK, Grindlay D and Williams HC (2009) *Skin Conditions in the UK: A Health Care Needs Assessment*. Nottingham: Centre of Evidence Based Dermatology. (Available at www.nottingham.ac.uk/scs/documents/documentsdivisions/documentsdermatology/hcnaskinconditionsuk2009.pdf)

APPENDIX E

Links to other services

Examples of Level 4 services to which identified links should be established within a health community. The services offered and the types of condition treated are included for completion. It should be noted that many district general hospitals offer some of these services, which should not necessarily be considered supra-specialist.

Supra-specialist (Level 4) service	Types of conditions seen	Services offered
Dermatological surgery and laser unit	Complex, large and difficult to manage skin cancers. Extensive birthmarks requiring laser treatment.	Access to Mohs micrographic surgery and complex reconstructive surgery involving joint working with a range of specialist plastic and reconstructive surgeons. Specialist laser services.
Skin cancer services	Rare skin tumours such as those identified within the NICE Improving Outcomes Guidance as within the remit of the specialist skin cancer multidisciplinary team (SSMDT).	Management of rare tumours involving multidisciplinary working with medical oncology/plastic and reconstructive surgeons as appropriate. Photophoresis services.
Inflammatory skin disorders	Psoriasis and eczema unresponsive to conventional treatment. Immunobullous disorders. Alopecia.	Complex assessment of patient needs and management, multidisciplinary team working, availability of specialised intensive nursing care, access to complex/high-risk therapies (biologic agents/immunotherapy).
Inpatient services	Severe inflammatory dermatoses, such as eczema, psoriasis, blistering disorders, drug eruptions, where out-patient care has proved unsuccessful. Life-threatening skin conditions, such as toxic epidermal necrolysis or other sick skin conditions.	Specialist nursing care and support.
Paediatric dermatology	Complex cases of common paediatric dermatoses. Rare paediatric dermatoses and genetic diseases. Children with vascular anomalies/complicated haemangiomas and complex birthmarks.	Enhanced clinical setting with access to specialist management and multidisciplinary team, including paediatric dermatology, interventional radiology, plastic surgery and laser services and specialist nursing, dietetics and psychology.

Supra-specialist (Level 4) service	Types of conditions seen	Services offered
Allergy services	Complex cases of allergic contact dermatitis, including occupational dermatitis, urticaria.	Highly specialist allergy testing, access to immunotherapy and biologic therapy.
Genetic dermatology	Rare and severe inherited skin diseases.	Diagnostic and genetic counselling service, outreach (to community and district general hospital) nursing service.
Photodermatology	Skin disorders related to sunlight, including rare conditions such as porphyria and xeroderma pigmentosum.	Specialist diagnostic services, including light testing.
Lymphovascular services	Patients with skin disease related to lymphovascular disorders.	Diagnosis and management.
Connective tissue disorders	Systemic lupus erythematosus and a whole range of other conditions.	Multidisciplinary team working particularly with rheumatologists.
Genital dermatology	Genital dermatoses, including patients with complex vulval and penoscrotal disorders. Patients with HIV.	Enhanced diagnostic skills, multidisciplinary management of men and women involving urologists, gynaecologists, sexual health clinicians and psycho-sexual practitioners as required.
Psychodermatology	Skin problems related to mental illness.	Psychiatric and psychological assessment and treatment as appropriate.
Specialist laboratory services	Rare dermatological conditions.	Immunohistochemistry, mutation analysis, prenatal diagnostic services, molecular diagnostic services using polymerase chain reaction (PCR).
Research	Any skin disease requiring evaluation of new treatments or investigation of the basic science underlying the condition.	Recruitment of patients into studies of new therapeutic agents, such as biologic agents (which are now available in district general hospitals). Basic scientific research into the causes of skin disease.

APPENDIX F

Clinical guidance, audit and risk management

NICE guidance relevant to care of people with skin conditions

This list is not exhaustive and up to date information is available at <http://guidance.nice.org.uk/Topic/Skin>

Guidelines

- skin tumours including malignant melanoma
- atopic eczema in children

Public health guidance

- skin cancer prevention

Health technology appraisals

- atopic dermatitis, tacrolimus and pimecrolimus
- atopic dermatitis, topical steroids
- a range relevant to biological treatments for psoriasis
- alitretinoin HTA

Interventional procedures

- photodynamic therapy

Suggested annual audit topics for dermatology services

Skin cancer:

- melanoma and squamous cell carcinoma - audit of information given to patients, in particular relating to key worker and documentation in the consultation record
- multidisciplinary team reporting and actions
- peer review feedback
- basal cell carcinoma, excision margins

Audit of management

(process and outcomes) against NICE and other national guidance, for example:

- biological therapies
- alitretinoin
- contact dermatitis
- isotretinoin prescribing - audit of patient care including information provided, concordance with pregnancy prevention programme and outcome of treatment

Wound infection rates

Casenote documentation/record keeping audit

APPENDIX G

Key performance indicators (KPIs)

Standards 2 to 8 each contain KPIs. They are listed here for ease of reference.

In monitoring performance, commissioners are urged to use these KPIs in conjunction with:

- relevant national targets
- audit outcomes identified in BAD national guidelines
- all measurable quality benchmarks identified in this document

It may be useful for local networks to develop and support further KPIs

STANDARD 2 Patient and public involvement

2.3.1

Evidence from providers of services managing skin conditions that they have developed and implemented an annual patient and public involvement plan, which includes use of PREMs and PROMs, an effective patient panel, evidence of patient feedback and the provider's response to this.

2.3.2

Evidence of public and patient involvement when changes to services are proposed.

STANDARD 3 Appropriately trained staff

3.3.1

Competence to deliver services: percentage of staff delivering dermatological services who have successfully completed competence-based training, according to their job role and scope of practice, and fulfilled relevant update requirements. (Standard 100%)

STANDARD 4 Clinical assessment and management

4.3.1

Adherence to current national and local guidelines.

STANDARD 5 Models of care and links to other services

5.3.1

Compliance with NICE guidance and, in its absence, with acknowledged best practice and/or local guidance.

5.3.2

Evidence that a range of integrated services has been developed using consensus guidance.

5.3.3

Adherence to the NHS Act 2006 and the NHS Constitution.

STANDARD 6 Diagnostic investigations

6.3.1

Percentage of preliminary reports that are received by clinicians within seven working days of a specimen being taken.(standard 100%)

STANDARD 7 Clinical governance

7.3.1

Audit:

Providers of services for people with skin conditions should be able to demonstrate:

- a named identified clinical governance lead
- evidence of annual participation in local, regional and national audit programmes and completion of an annual audit plan with guidelines and protocols as appropriate (for an example of the annual audit requirements for a dermatology department, see Appendix E)
- evidence that healthcare professionals meet all the statutory requirements to practise, including any in respect of continuing professional development (for more detail see Standard 3)
- documented evidence that facilities meet agreed national standards

7.3.2

Patient-recorded experience measures (PREMs), as described in Standard 2.
(Standard: over 90% positive patient experience.)

STANDARD 8 Information governance

8.3.1

Service providers are registered with the Information Commissioner for data processing.
(Standard: 100%)

8.3.2

Service providers have an information governance policy in place to ensure legal and national guidelines are followed. (Standard 100%)

Glossary of abbreviations

BAD	British Association of Dermatologists
BASHH	British Association for Sexual Health and HIV
BDNG	British Dermatological Nursing Group
BSPD	British Society for Paediatric Dermatology
CATS	clinical assessment and treatment services
CCT	Certificate of Completion of Training
CESR	Certificate of Eligibility for Specialist Registration
CPA	Clinical Pathology Accreditation
CPD	continuing professional development
DH	Department of Health
EPP	Expert Patient Programme
EQAS	external quality assessment scheme
GMC	General Medical Council
GP	General Practitioner
GPwSI	GP with a Special Interest
GUM	genitourinary medicine
HPC	Health Professional Council
IVD	in vitro diagnostic
KSF	knowledge skills framework
LINKs	local involvement networks
MDT	multidisciplinary team
MHRA	Medicines and Healthcare Products Regulatory Agency
NES	National Eczema Society
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NPSA	National Patient Safety Agency
NTN	National Training Number
NVQ	National Vocational Qualification
PCDS	Primary Care Dermatology Society
PhwSI	Pharmacist with a Special Interest
PREM	patient-recorded experience measure
PROM	patient-recorded outcome measure
RCGP	Royal College of General Practitioners
RPS	Royal Pharmaceutical Society
SCC	Skin Care Campaign
TSSG	tumour site specific group
UKAS	United Kingdom Accreditation Service

